FREEDOM ACADEMY PERSONAL INFORMATION (Please PRINT)

DELEGATE NAME:_____SSN: _____

ADDRESS:_____
MAILING ADDRESS CITY STATE ZIP

HOME TELEPHONE:_____
AREA CODE PHONE NUMBER

DATE OF BIRTH:_____

HIGH SCHOOL:_____

MAILING ADDRESS:_____

_____
CITY STATE ZIP

PARENT/GUARDIAN'S NAME: _____

DAYTIME WORK PHONE: _____
AREA CODE PHONE NUMBER

HEALTH INSURANCE PLAN:_____
Please attach a copy of your insurance card (both sides) to this form PRIOR to coming to the Academy.

INSURANCE CARRIER NUMBER:_____

ARE YOU ALLERGIC TO ANY MEDICATIONS?_____

CURRENT MEDICATIONS:_____

PLEASE LIST ANY CHRONIC MEDICAL CONDITIONS: (i.e. acne, asthma, diabetes, epilepsy, thyroid)

_____

PLEASE LIST ANY INJURIES: _____

PLEASE LIST ANY PHYSICAL LIMITATIONS _____

SPECIAL NOTE: Medical Insurance Coverage must be validated prior to registration (show your card).

Medications cannot be dispensed to delegates from the medical clinic during Michigan Freedom Academy. Delegates requiring aspirin, prescription medications, allergy tablets, etc., must be brought from home. Delegates must bring medications needed or anticipated (i.e., bee sting kits, etc.) with them in sufficient quantity.

IF ANY OF THE ABOVE CONDITIONS CHANGE, PLEASE NOTIFY THE ACADEMY NURSE DURING REGISTRATION.